



City of Waukesha Parks, Recreation & Forestry
Authorization to Administer Prescribed or Over the Counter Medication



**ONLY NEEDS TO BE COMPLETED AND RETURNED IF YOUR CHILD WILL BE TAKING
MEDICATION AT THE COOL SCHOOL "REC"/SUMMER EXPLORERS PROGRAM**

Child's Name: _____ **Date of Birth:** _____
Address: _____ **City:** _____ **Zip:** _____
Program Site: _____ **Parent/Guardian:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Prescribed Medication Only - PHYSICIAN ORDER

I am prescribing medication for (child's name) _____ which is as follows:

Name of Medication	Dosage	Form of Administration	Time	Possible Adverse Side Effects

For inhaled medications, only – check appropriate line:

_____ In my opinion, this student demonstrates the ability to carry and self-administer the above medication. If not checked WPRF staff will carry and help administer this medication.

Physician's Name: _____ **Phone Number:** _____
Physician's Signature: _____ **Date:** _____

Over the Counter Medication – Parent Order

Name of Medication	Dosage	Form of Administration	Time	Possible Adverse Side Effects

I give permission for my son/daughter to receive the medication authorized by his/her physician. I give permission to share this information with the appropriate WPRF staff. I will:

- 1.) Deliver medication to Cool School "Rec"/Summer Explorers Staff in pharmacy-labeled container (Prescription only) or original container/packaging (over the counter only).
- 2.) Maintain a sufficient supply of medication at daily.
- 3.) Obtain a new authorization form if any changes occur with this medication.
- 4.) Pick up any un-used medication.

The above order shall remain in effect through the end of the program for the Summer of 2018 unless discontinued, changed by the physician, or if the parent/guardian withdraws the request in writing.

Parent/Guardian Signature: _____ **Date:** _____